Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

August 19, 2016

Ms. Sharon Sylvester, Administrator
Blue Spruce Home For The Retired
70 Birch Street
Bradford, VT 05033-9027

Dear Ms. Sylvester:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 20, 2016**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0194	A. BUILDING: _____ B. WING _____	R 07/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE SPRUCE HOME FOR THE RETIRED	70 BIRCH STREET BRADFORD, VT 05033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R100}	Initial Comments: An unannounced onsite follow up to the re-licensing survey was conducted on 7/20/16. The following deficiencies cited on survey were found to not be corrected and remain out of compliance.	{R100}		
{R144} SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c.(1) Complete an assessment of the resident in accordance with section 5.7; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to ensure that assessments were reviewed and signed by the nurse for 1 of 3 residents sampled (Resident #3). Findings include: Per record review, Resident #3 had an assessment that was completed by the home's owner, however was not reviewed or signed by the Registered Nurse. On 7/20/16 at 10:45 AM, the home's manager confirmed that they had given the nurse a list of items found on the relicensing survey on 4/25/16 that needed the nurse to address, and that this was one of the assessments that needed the nurse's review and signature. The Manager confirmed that the nurse had not reviewed or signed the assessment for Resident #3.	{R144}	See attached 8/18/16 PoC accepted - see attachment Karen Campos	
{R145} SS=D	V. RESIDENT CARE AND HOME SERVICES	{R145}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIDN	(X1) PRDVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CDNSTRUCTION	(X3) DATE SURVEY COMPLETED
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{R145}	Continued From page 1 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to ensure that the plan of care was based on the abilities and needs as well as describing the care and services necessary for 1 of 3 residents sampled (Resident #1). Findings include: Per record review, Resident #1 was admitted to the home on 3/10/16, and they have conditions that require nursing oversight as well as medication administration by unlicensed staff. Per review of the record, there was only one brief entry on the plan of care, and did not list all the care needs of this resident. Per interview on 7/20/16 at 11:10 AM, the home's Manager stated that the nurse was supposed to write the plan of care as part of their plan of correction from the 4/25/16 survey, and that it had not been completed.	{R145}	See attached	
{R160} SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.a Each residential care home must have written policies and procedures describing the	{R160}		

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{R160}	Continued From page 2	{R160}	See attached	

home's medication management practices. The policies must cover at least the following:

(1) Level III homes must provide medication management under the supervision of a licensed nurse. Level IV homes must determine whether the home is capable of and willing to provide assistance with medications and/or administration of medications as provided under these regulations. Residents must be fully informed of the home's policy prior to admission.
(2) Who provides the professional nursing delegation if the home administers medications to residents unable to self-administer and how the process of delegation is to be carried out in the home.
(3) Qualifications of the staff who will be managing medications or administering medications and the home's process for nursing supervision of the staff.
(4) How medications shall be obtained for residents including choices of pharmacies.
(5) Procedures for documentation of medication administration.
(6) Procedures for disposing of outdated or unused medication, including designation of a person or persons with responsibility for disposal.
(7) Procedures for monitoring side effects of psychoactive medications.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the home failed to ensure that the Registered Nurse conducted assessments to determine potential medication side effects for 3 of 3 residents reviewed (Residents #1, #2, #3). Findings include:

1. Per record review of Resident #1, there was an

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{R160}	Continued From page 3	{R160}		

order for an anti-psychotic medication Quetiapine 300 mg. scheduled twice daily. This had increased on 4/20/16 from a dose of 200 mg. twice daily. There was also a PRN (as needed) order for 25 mg. in addition. There was no evidence that an assessment for side effects, specifically abnormal involuntary movements, was conducted by the Registered Nurse.

2. Per record review of Resident #2, there was an order from the MD on 2/23/16 for an antipsychotic medication Quetiapine 25 mg. 1-2 tabs scheduled daily at bedtime. There was also a PRN (as needed) order for 25 mg. in addition for agitation. Also on 3/22/16, a morning scheduled dose of this antipsychotic had been added. There was no evidence that an assessment for side effects, specifically abnormal involuntary movements, was conducted by the Registered Nurse.

3. Per review of Resident #3, there was an order for an antipsychotic medication Quetiapine 100 mg. at bedtime, and Quetiapine 50 mg. scheduled twice daily at 8 AM and 2 PM. There was no evidence in the record that an assessment for side effects, specifically abnormal involuntary movements, was conducted by the Registered Nurse.

Per interview on 7/20/16 at 1:30 PM, the Manager of the home confirmed that there were still no assessments completed by the nurse for the potential side effects of the antipsychotic medications for these three residents.

See attached

{R167} SS=F V. RESIDENT CARE AND HOME SERVICES {R167}

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{R167}	Continued From page 4 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (5) Staff other than a nurse may administer PRN psychoactive medications only when the home has a written plan for the use of the PRN medication which: describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to ensure that the Registered nurse developed a written plan for delegated unlicensed staff for the use of PRN psychoactive medication which: describes the specific behaviors the medication is intended to correct or address; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use for 2 of 3 residents sampled (Residents #1, #2). Findings include: 1. Per record review of Resident #1, there was an order for an antipsychotic medication Quetiapine 150 mg. scheduled twice daily. There was also a PRN (as needed) order for 25 mg. in addition. The physician's order was written as Quetiapine 25 mg., One tab by mouth as needed. There was	{R167}	See attached	

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{R167}	Continued From page 5 no reason to administer given in the order, and there was no written plan to guide staff in the appropriate use of this as needed antipsychotic medication. 2. Per record review of Resident #2, there was an order from the MD on 2/23/16 for an antipsychotic medication Quetiapine 25 mg. 1-2 tabs scheduled daily at bedtime for sleep. There was also a PRN (as needed) order for 25 mg. in addition for agitation. Also on 3/22/16, a morning scheduled dose 25 mg. of this antipsychotic had been added. There was no written plan to guide staff in the appropriate use of this as needed dose of the antipsychotic medication, and there was a dosage range in the scheduled bedtime dose that did not have any guidance for staff in choosing which dose to administer. Per interview on 7/20/16 at 2:20 PM, the home Manager confirmed that there still were no written plans developed by the nurse for staff to follow when considering the need for PRN antipsychotic medications for these two residents.	{R167}	See attached	
{R189} SS=B	V. RESIDENT CARE AND HOME SERVICES 5.12.b. (3) For residents requiring nursing care, including nursing overview or medication management, the record shall also contain: initial assessment; annual reassessment; significant change assessment; physician's admission statement and current orders; staff progress notes including changes in the resident's condition and action taken; and reports of physician visits, signed telephone orders and treatment documentation;	{R189}		

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{R189}	Continued From page 6 and resident plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the home failed to ensure that for residents requiring nursing care, including nursing overview or medication management, the medical record contained all the required assessments and plans of care for 2 of 3 residents sample(Residents #1, #3). Findings include: 1. Resident #3 did not have a Resident Assessment completed, reviewed, or signed by the nurse. 2. Resident #1 did not have a written plan of care developed and signed by the nurse. Per interview on 7/20/16 at 2:15 PM, the Manager of the home confirmed that the plan of care had not been written for Resident #1, and that the Resident Assessment for Resident #3 had not been reviewed and signed by the nurse.	{R189}	See attached	

R144 Resident Care and Home Service

5.9c (1)

Resident #3's assessment was over looked and not signed by the RN. RN came in looked over the assessment and signed off the assessment. The plan of correction is in place 8/4/2016

R144 POC accepted 8/18/16
K Campos RN

R145 Resident care and Home Service

5.9c (2)

Resident #1's care plan was done and signed, but was not complete. It needed more information. The RN came into the home, went over the care plan and added more information and signed off on it. Plan of correction completed and in place 8/4/2016

R145 8/18/16 POC accepted
K Campos
RN

R160 Resident Care and Home Service

5.10 Medication Management

5.10a

Resident #1 is on antipsychotic medication. The RN was to do AIM's assessment on the resident. The assessment was not completed. The RN came in did AIM's assessment and signed off on the form.

Resident #2 has a PRN order for antipsychotic medication. The RN was supposed to fill out an AIM testing form and it was not completed. The RN came in did an AIM's assessment and signed off on it.

Resident #3 need to have an AIM's assessment done in which the RN did not complete. The RN came in did the AIM's elevation and signed off on the form.

Plan of correction completed and in place 8/4/2016

8/18/16 POC accepted
R160 K. Campos
RN

R167 Resident Care and Home Service

5.10 Medication Management

5.10d

Resident #1 and #2 have PRN orders for antipsychotic medication. The RN was to write up orders for the staff to know when to administer PRN medication, which was not complete. The RN came in wrote the orders with directions. The orders were placed in the medication book for all employees to see. The plan of correction is in place and completed 8/4/2016

R167
POC accepted 8/18/16
K. Campos
RN

R189 Resident Care and Home Service

5.12 (3)

Resident #3's assessment was completed, but not signed off by the RN. The RN came in and signed the completed assessment.

Resident #1's care plane was not completed or fully developed. The RN finished care plan and added to it, so that it is fully developed.

The plan of correction is in place and completed 8/4/2016

R189
POC accepted 8/18/16
K. Campo